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IMPORTANCE OF THE FAMILY IN THE CARE PROCESS: ATTITUDES OF NURSES IN THE CONTEXT OF INTENSIVE THERAPY

IMPORTÂNCIA DA FAMÍLIA NO PROCESSO DE CUIDADOS: ATITUDES DE ENFERMEIROS NO CONTEXTO DA TERAPIA INTENSIVA

IMPORTANCIA DE LA FAMILIA EN EL PROCESO DE CUIDADOS: ACTITUDES DE ENFERMEROS EN EL CONTEXTO DE LA TERAPIA INTENSIVA

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ABSTRACT

Objective: to identify nurses' attitudes about the importance of families in the care process in the context of intensive care. **Method:** this is a quantitative, descriptive and transversal study, with 43 nurses from two public health institutions. Families' Importance in Nursing Care - Nurses Attitudes (IFCE-AE) scale was used, consisting of 26 items and a total score of 104 points, in which the nurses' attitudes were categorized into three dimensions: Family: dialogue partner and coping resource; Family: resource in nursing care; and Family: burden. **Results:** the total mean of the IFCE - AE was 75.1, in which the nurses took care of the family. The averages of the second dimension Family dialogue and coping resource was 34.4; and 30.0 and 10.06 in the Family resource dimensions in nursing care and Family Burden, respectively. **Conclusion:** The overall mean of the IFCE-AE found in the research suggested that nurses assume caregiving attitudes toward the family. **Descriptors:** Nursing; Family Nursing; Critical Care.

RESUMO

Objetivo: identificar atitudes de enfermeiros sobre a importância das famílias no processo de cuidados no contexto da terapia intensiva. **Método:** estudo quantitativo, descritivo e transversal, com 43 enfermeiros de duas instituições públicas de saúde. Foi utilizada a escala Families' Importance in Nursing Care - Nurses Attitudes (IFCE-AE) composta por 26 itens e escore total de 104 pontos, na qual as atitudes dos enfermeiros foram categorizadas em três dimensões: Família: parceiro dialogante e recurso de *coping*; Família: recurso nos cuidados de enfermagem; e Família: fardo. **Resultados:** a média total da IFCE - AE foi 75,1, na qual os enfermeiros assumem atitudes de cuidado à família. As médias da segunda dimensão Família parceiro dialogante e recurso de *coping* foi 34,4; e de 30,0 e 10,06 nas dimensões Família recurso nos cuidados de enfermagem e Família Fardo, respectivamente. **Conclusão:** a média geral da IFCE-AE encontrada na pesquisa sugeriu que os enfermeiros assumem atitudes de cuidado perante a família. **Descritores:** Enfermagem; Enfermagem de Família; Cuidados Críticos.

RESUMEN

Objetivo: identificar actitudes de enfermeros sobre la importancia de las familias en el proceso de cuidados en el contexto de la terapia intensiva. **Método:** estudio cuantitativo, descriptivo y transversal, con 43 enfermeros de dos instituciones públicas de salud. Fue utilizada la escala Families' Importance in Nursing Care - Nurses Attitudes (IFCE-AE) compuesta por 26 items y puntaje total de 104 puntos, en la cual las actitudes de los enfermeros fueron categorizadas en tres dimensiones: Familia: compañero dialogante y recurso de *coping*; Familia: recurso en los cuidados de enfermería; y Familia: fardo. **Resultados:** la media total de la IFCE - AE fue 75,1, en la cual los enfermeros asumen actitudes de cuidado a la familia. Las medias de la segunda dimensión Familia compañero dialogante y recurso de *coping* fue 34,4; y de 30,0 y 10,06 en las dimensiones Familia recurso en los cuidados de enfermería y Familia Fardo, respectivamente. **Conclusión:** la media general de la IFCE-AE encontrada en la investigación sugirió que los enfermeros asumen actitudes de cuidado frente a la familia. **Descriptores:** Enfermería Familiar; Enfermería Familiar; Cuidados Críticos.

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INTRODUCTION

The Intensive Care Unit (ICU) has specific characteristics unlike other units and its dynamics impose complex actions, in which the finitude of life is a constant, generating anxiety in the patient, in the family and in the professionals who carry out their activities.¹ As a result of the great immediate technological contribution, the initial contact with the family members is often difficult, contributing to the understanding of the ICU as a place where the coldness and the inhumane and distant performance prevail. However, the interaction with the families needs to take place from the time of the patient's hospitalization, providing them with an opportunity to dialogue and clarify doubts.² Nurses are responsible for the commitment and responsibility to include families in health care since the family's meaning for the well-being and health of its members, as well as the influence on the illness, obliges this professional to consider family-centered care as an integral part of nursing practice.³

Family-Centered Care (FCC) aims to promote the health and well-being of individuals and families, as well as to restore their control and dignity without eliminating the individual competence of each member in the decision-making. their own health.^{4,5} The Family-Centered Care Institute defines this type of approach as a planning, delivery, and assessment process for care that is dynamically sustained in partnering with mutual benefits for patients, families and professionals.⁶ in this model, there is an important component - the attitude - that involves affective, cognitive and behavioral dimensions as a response to a stimulus. Thus, the presence of the family in the healthcare environment is the stimulus necessary to trigger attitudes that the nurse will assume towards it, being based on feelings and emotions (affective component), thoughts and beliefs (cognitive component), and trends to react.⁷

Although the ICU is a context of intense technological innovations through equipment and life support, the conditions to develop the work process with patients and their families did not follow this evolution, so the search for knowledge and innovation about family care in space of the ICU becomes necessary. In view of the above, the question is: What attitudes are adopted by nurses working in the intensive care unit to value the family as a unit of care?

OBJECTIVE

- To identify nurses' attitudes about the importance of families in the care process in the context of intensive care.

METHOD

This article is part of the Master's Dissertation defended in March 2017, in the Graduate Program in Nursing, Federal University of Maranhão, entitled "Importance of the family in the care process: attitudes of nurses in the context of the intensive care unit."

This is a quantitative, descriptive and transversal study, developed in two public health institutions of reference in the state of Maranhão in intensive care, both located in the municipality of São Luís (capital of the state of Maranhão). The population was constituted by all nurses working in the units described above, totaling 43 professionals. When organized by sector where they carry out their activities, the population was distributed as follows: General ICU (19 nurses); Cardiac ICU (13 nurses); Hemodynamics (05 nurses); ICU (06 nurses). Considering that analyzing the study population is a feasible condition, it was chosen not to make a sample calculation, but to consider integrally the number of nurses from the selected sites for the research. Inclusion criteria were defined as being a nurse of the institutions and services selected as a research site and with a care function for at least six (06) months.

As a tool to identify the nurses' attitudes towards the valorization of the family in the care process, the Families' Importance in Nursing Care - Nurses Attitudes (FINC-NA) scale was translated and validated in Brazil as "A Importância das Famílias nos Cuidados de Enfermagem - Atitudes dos Enfermeiros - IFCE-AE."⁷ This is a self-filling scale of the Likert type composed of 26 items with four response options (completely disagree, disagree, agree and completely agree). The score of each item ranges from 1 to 4, and from the total IFCE-AE scale from 26 to 104.⁷ Nurses' attitudes were categorized according to the IFCE-AE scale in three dimensions: Family: a partner dialogue and a coping resource, Family: resource in nursing care; and Family: burden. For the analysis, it was considered that the higher the score obtained in the first two dimensions and the lower in the third, the more important the nurses attribute to the family care.

For data collection, the IFCE-AE Scale, the guidelines for completion and the Free and Informed Consent Form were delivered personally to each of the participants in their work units. The instrument was returned within 10 working days. If it was not returned within that time, a new date was scheduled. Data collection was initiated in May and completed in September 2016 by two researchers who received prior training to take doubts and conduct this step in a uniform

way. /the project was submitted to the Brazil Platform with a favorable opinion from the Research Ethics Committee of the University Hospital of UFMA under registration number 1,249,885 to meet the ethical criteria of the research. After data collection, they were entered into the Microsoft Access® Program with double typing and then analyzed by STATA® software v.12.1.

RESULTS

Table 1. Attitudes of Nurses working in the Intensive Care Unit facing the importance of families according to the IFCE-AE scale and dimensions. São Luís - (MA), Brazil (2016)

Dimensions	Mean/Standard Deviation	Minimum and Maximum scores	Confidence Interval 95%
Total IFCE- Total AE	75.1/6.7	58 - 95	72.4 - 77.9
Family: dialogue partner and coping resource	34.4/3.6	26 - 46	32.9 - 35.9
Family: resource in nursing care	30.0/3.2	20 - 39	28.7 - 31.3
Family: bale	10.6/1.4	7 - 13	10.1 - 11.1

The mean of the total score of the IFCE-AE scale was 75.1 points (SD=6.7 and CI=72.4-77.9) indicating that the nurses at the ICUs investigated had a positive attitude about the importance of families in the care of nursing. Regarding the Family: dialogue and coping resource, the mean score was 34.4 points (SD=3.6, CI=32.9-35.9); in the dimension

Family: resource in nursing care, was 30 points (SD=3.2, CI=28.7-31.3); and in the Family: burden dimension, the mean score was 10.6 points (SD=1.4, CI=10.1-11.1), demonstrating that, in general, the family is not considered a burden on care by the nurses studied.

Table 2. Attitudes of intensive care nurses in relation to the Family dimension: dialogue partner and coping resource in the context of Intensive Care. São Luís - (MA), Brazil (2016)

ITEM 4 - Family members should be invited to participate actively in the patient's nursing care				
Completely disagree	Disagree	Agree	Completely agree	Total
03 (6.98%)	11 (25.58%)	20 (46.51%)	09 (20.93%)	43 (100%)
ITEM 6 - In the first contact with family members, I invited them to participate in the discussions about the patient care process				
Completely disagree	Disagree	Agree	Completely agree	Total
03 (6.98%)	11 (25.58%)	20 (46.51%)	09 (20.93%)	43 (100%)
ITEM 9 - Discussing with family members during the first contact about the care process, saves me time in my future work				
Completely disagree	Disagree	Agree	Completely agree	Total
01 (2.33%)	11 (25.58%)	23 (53.49%)	08 (18.60%)	43 (100%)
ITEM 12 - I always try to know who the family members are				
Completely disagree	Disagree	Agree	Completely agree	Total
00 (0.00%)	07 (16.28%)	28 (65.12%)	08 (18.60%)	43 (100%)
ITEM 14 - I invite family members to talk aftercare				
Completely disagree	Disagree	Agree	Completely agree	Total
01 (2.33%)	08 (18.60%)	28(65.12%)	06 (13.95%)	43 (100%)
ITEM 15 - I invite family members to actively participate in patient care				
Completely disagree	Disagree	Agree	Completely agree	Total
03 (6.98%)	11 (25.58%)	20 (46.51%)	09 (20.93%)	43 (100%)
ITEM 16 - I ask families how I can help them				
Completely disagree	Disagree	Agree	Completely agree	Total
01 (2.33%)	05 (11.63%)	27 (62.79%)	10 (23.26%)	43 (100%)
ITEM 17- I encourage families to use their resources so they can better deal with the situations				
Completely disagree	Disagree	Agree	Completely agree	Total
02 (4.65%)	09 (20.93%)	23 (53.49%)	09 (20.93%)	43 (100%)
ITEM 18 - I consider family members as partners				
Completely disagree	Disagree	Agree	Completely agree	Total
1 (2.33%)	04 (9.30%)	29 (67.44%)	09 (20.93%)	43 (100%)
ITEM 19 - I invite family members to talk about changes in the patient's condition				
Completely disagree	Disagree	Agree	Completely agree	Total
1 (2.33%)	04 (9.30%)	29 (67.44%)	09 (20.93%)	43 (100%)
ITEM 24 - I invite family members to give their opinion on care planning				
Completely disagree	Disagree	Agree	Completely agree	Total

03 (6.98%)	17 (39.53%)	20 (46.51%)	03 (6.98%)	43 (100%)
ITEM 25 - I see myself as a resource for families so they can deal as best they can with their situation				
Completely disagree	Disagree	Agree	Completely agree	Total
00 (0.00%)	05 (11.63%)	31 (72.09%)	07 (16.28%)	43 (100%)

In this dimension, when added to the “I Agree” and “I Completely Agree” answers, 67.44% of the nurses consider it important that family members should be invited to participate actively in the patient's nursing care; that in the first contact with the family members, 67.44%, the nurses invite the family to participate in the discussions about the patient care process; 72.09% agreed that discussing with family members during the first contact, about the care process, saves time in their future work; 83.72% always sought to know who the members of the

patient's family were; 79.06% invited family members to talk after care; 83.72% asked families how they could help them; 74.41% encouraged families to use their resources so they could better deal with situations; 88.3% considered family members as partners; 88.37% asked family members to talk about changes in the patient's condition; 53.48% asked family members to give their opinion on care planning; and 88.37% saw themselves as a resource for families so that they could deal as best they could with their situation.

Table 3. Attitudes of Intensive Care nurses in the dimension of Family: resource in nursing care in the context of Intensive Care, São Luís - (MA), Brazil (2016)				
ITEM 1 - It is important to know who the family members of the patient are				
Completely disagree	Disagree	Agree	Completely agree	Total
0 (0.00%)	1(2.32%)	19(44.19%)	23 (53.49%)	43 (100%)
ITEM 3 - A good relationship with family members gives me job satisfaction				
Completely disagree	Disagree	Agree	Completely agree	Total
0 (0.00%)	0(0.00%)	24(55.81%)	19(44.19%)	43 (100%)
ITEM 5 - The presence of family members is important to me as a nurse				
Completely disagree	Disagree	Agree	Completely agree	Total
1 (2.33%)	7 (16.28%)	4 (9.09%)	11 (25.58%)	43 (100%)
ITEM 7 - The presence of family members gives me a sense of security				
Completely disagree	Disagree	Agree	Completely agree	Total
1 (2.33%)	15(34.88%)	22(51.16%)	5(11.63%)	43 (100%)
ITEM 10 - The presence of family members alleviates my workload				
Completely disagree	Disagree	Agree	Completely agree	Total
8 (18.60%)	21(48.84%)	12(27.91%)	2(4.65%)	43 (100%)
ITEM 11 - Family members should be invited to participate actively in planning care for the patient				
Completely disagree	Disagree	Agree	Completely agree	Total
2 (4.65%)	9 (20.93%)	28 (65.12%)	4 (9.30%)	43 (100%)
ITEM 13 - The presence of family members is important to family members themselves				
Completely disagree	Disagree	Agree	Completely agree	Total
0 (0.00%)	2(4.65%)	28(65.12%)	13(30.23%)	43 (100%)
ITEM 20 - My involvement with families makes me feel useful				
Completely disagree	Disagree	Agree	Completely agree	Total
2 (4.65%)	3 (6.98%)	32 (74.42%)	6 (13.95%)	43 (100%)
ITEM 21 - I gain a lot of valuable insights from families, which I can use in my work				
Completely disagree	Disagree	Agree	Completely agree	Total
1(2.33%)	7(16.28%)	25(58.14%)	10 (23.26%)	43 (100%)
ITEM 22 - It is important to devote time to families				
Completely disagree	Disagree	Agree	Completely agree	Total
0 (0.00%)	7 (16.28%)	25 (58.14%)	11 (25.58%)	43 (100%)

The data on the dimension Family: nursing care resource shows that nurses considered the family as a resource in care, being valued for its expertise, skill, and ability, making it co-responsible in health-disease processes. In this dimension, when added to the answers "I agree" and "I completely agree" 97,68% of the nurses accepted that it is important to know who the members of the patient's family were; 100% agreed that a good relationship with family members gave them satisfaction at work; 81.39% decided that the presence of family members was important to them as a nurse; when questioned about whether the presence of family members gave a sense of security, 62.79% said that they agree with this

statement; for 74.42% of nurses, family members should be invited to participate actively in planning care for the patient; when asked if the presence of family members was important to family members themselves, 95.35% agreed with this statement; 88.37% mentioned that their involvement with families made them feel useful; 81.40% agreed that nurses were gaining valuable insights with families, that they could use at work, and still reported that it was important to devote time to families, 83.72% agreed with this statement. Regarding attitude, the presence of family members relieved my workload, 67.44% of nurses disagreed as important to the care process.

Table 4. Attitudes of intensive care nurses in the Family dimension: burden in the context of Intensive Care, São Luís (MA), Brazil (2016)

ITEM 2 - The presence of family members makes my work difficult				
Completely disagree	Disagree	Agree	Completely Disagree	Total
2 (4.65%)	26(60.47%)	13(30.23%)	2 (4.65%)	43 (100%)
ITEM 8 - I do not have time to take care of the Family				
Completely disagree	Disagree	Agree	Completely Disagree	Total
10 (23.26%)	21(48.84%)	10(23.26%)	2 (4.65%)	43 (100%)
ITEM 23 - The presence of family members makes me feel valued				
Completely disagree	Disagree	Agree	Completely Disagree	Total
0 (0.00%)	10(23.26%)	28(65.12%)	5 (11.63%)	43 (100%)
ITEM 26 - The presence of family members leaves me stressed				
Completely disagree	Disagree	Agree	Completely Disagree	Total
8 (18.60%)	28(65.12%)	6(13.95%)	1 (2.33%)	43 (100%)

In this dimension, when added to the “Disagree” and “Completelly Disagree” answers, 65.12% of the nurses considered that the presence of family members made their work difficult; 71.10% indicated that they did not have time to take care of the families, and 83.72% reported that the presence of the family made them stressed. As if the presence of family members made them feel valued, 76.75% of the nurses agreed with this statement. In this dimension, it was the attitude in which the frequency of agreement was greater when compared with the others.

DISCUSSION

Although the overall mean of the IFCE-AE scale and the dimensions defined by it were compatible with positive attitudes towards family valuation in the care of nurses, it is considered a lower average when compared to the study developed in a pediatric unit in which the total IFCE-AE was 82 points. In the dimension Family: partner dialogue and coping resource, the MEAN score was 37 points; in the dimension Family: resource in nursing care, was 33; and the dimension

Family: burden, the average score was 12 points⁷. Therefore, it can be inferred that it is necessary to invest in training for the valorization of the family in nursing care, considering that one of the consequences of the dominant medical model “is that nurses have renounced many of their traditional functions of caring in favor of assuming more tasks and functions instead of focusing on the person”^{8:10}, and that health systems tend to focus on the problem rather than people and their needs. They are conditions that challenge nurses to work with individuals and their families by characterizing as a change of focus, behaviors, and attitudes, representing a new way of thinking, being and doing in care relationships. It suggests a redefinition of nurses' roles for care, especially collaborative care, in which the person and the family are not passive recipients, but a care partner, though there is no common sense of the different ways of caring, but the which should be questioned are the values that professionals attribute to their actions, since they determine and reveal the commitments and responsibilities towards the other⁹. Therefore, it concerns the human essence,

Chaves RGR, Sousa FGM de, Silva ACO et al.

Importance of the family in the care process...

but above all, the choices and options we make in caring relationships.

According to the Family Dimension: partner dialogue and coping resource, nurses recognize the importance of shared care, dialogue and negotiation, which implies the ability to discuss with family members about the care process, talking and talking about the state of the patient. These attitudes are imbued with characteristics that determine care based on horizontal and complementary relationships marked by openness to new and diverse opinions, as well as the reception of families, involving the ability to value family experiences, flexibility, tolerance and reflective thinking.

It also concerns the ability to listen attentively and authentic presence. Listening is “necessary to build connections and sustain a relationship,” and that “(re) forming commitment and clinical involvement requires training the ear to listen to patients and families, concerns, pain and suffering”^{8:3}. For the student, the nurse can develop skills to be an attentive listener, emphasizing that attentive listening begins with the nurse being fully present and having an open mind to hear the patient's sounds, what he has to say and the way he says, and to distinguish between different forms of communication. Presence is the professional's way of being with the person seeking help and is defined as an essential ingredient of any helping relationship since it fosters the professional's empathy and understanding of what the other person experiences. It suggests the condition of the professional to become a resource and to find ways to support the person in what is important to him and to be committed to the person and his/her situation in which there is a progression from a condition of ignorance to that of knowledge⁸. However, authentic presence is “a matter of choice”^{8:3}, that is, the nurse can choose to be completely engaged or distant, uncommitted, uninterested and uninvolved. Therefore, “valuing listening and dialogue is an attribute that is placed in the same order of technical competence”^{11:15}, representing the manifestation of interest and availability of the professional permeated by the eye and observing and seeing the other in its uniqueness.

The sick person is part of a family, so considering and knowing the family is an important supportive attitude for the extended care of the nurse when hospitalized in intensive care. Searching to know who the family members are, that is family composition, is an important strategy for

intervention in the family⁴. The authors emphasize that besides to defining the structure of the family, it is necessary to establish the bonds, the affective attributes and the relationships between family members and suggest that the genogram and the ecomap should be used as family assessment instruments to delineate the internal and external structures of the family. This perspective includes the family as a unit of care and as a focus of care for Nursing and, above all, considers the family from a systemic perspective and thus shares alliances and responsibilities to face the challenges of the health-disease process.

As for the attitude, I invite the family members to give their opinion on the planning of care, 46.51% of the nurses disagreed with this statement. It was the attitude in which the frequency of agreement was lower (43.51%) when compared with the others. On a closer look, this attitude may reveal vertical, power and authoritarian relations, as well as the valuation of illness and instrumental technique, revealing, also, indifference in the care relationships in which nursing focuses on the disease, not the individual and his family.

The items of the Family dimension: partner dialogue and coping resource lead to understanding nurses' care based on the subjective dimension through which interaction and the dialogic relationship circulate as structuring elements. In this perspective, the family becomes a nursing client and, in itself, suggests an interactive process in which closeness and bonding give body and structure to care and through which bridges are created to sustain and enable new interactions. Interaction enables the simultaneous follow-up of the patient and the family,¹² and therefore, the moments of meetings between the family and the professionals should happen frequently, allowing them to ask questions, expressing concerns and finding comfort and compassion by the professionals¹³. Caring, in this perspective, is characterized by “a relationship in which the nurse is emotionally present to the other, communicating continuous availability and sharing feelings”^{14:7}, based on human interaction. This creates a self-sustaining system that adds to the family's well-being and care that is congruent with the field of needs.

Thus, caring for both the patient and the family is an emerging necessity for the nurse, because when a family member is hospitalized, the family accompanied by feelings of fear, anguish, insecurity, and

uncertainties, in a climate of vulnerability, disorder and restlessness¹⁵. Therefore, family monitoring is also necessary and nurses' care functions as a support and facilitator of the process. However, the "professional silence has turned out to be deafening"^{15:13} in a poor relationship in interactions and fragile communication. In this scenario, the family is seen as a visit, not as a care unit. On the contrary, when the family is valued in care relationships it leaves significant marks in which the competence and the sensitivity of the professional make the difference.

The centrality of care in the sick person through therapeutic measures and constant monitoring tends to divert the attention of the nurse to the patient¹⁶. On the other hand, family participation in care is facilitating, since it contributes to a better understanding of the illness situation and results in gains for the family not only because of the knowledge they acquire but also because of the importance of their presence to the patient¹⁷. Engaging the family is a motivational behavior in the care of nurses, guided by the patient's desire for improvement and how he or she will be cared for by the family, constituting the nurse's foci to minimize suffering with the experience of illness¹⁸.

The components of the dimension Family: resource in nursing care lead to understand nurses' care in the particular dimension of care through which interaction and communication circulate as structuring elements since care is subjective and the best way for their understanding is the ability to relate to one another¹⁹. Understanding the family as a resource in nursing care is to bring the same to be welcomed with a view to the reorganization of nursing practice.

From the care negotiated and shared in each unique situation, the autonomy of the family is promoted and, at the same time, the demands of family care²⁰ are respected. This condition is the result of an increasingly active participation of families in the health and illness process of their members and presupposes that nurses rethink their way of equating and practicing health care, considering family-centered care as an integral part of the nursing practice²¹.

It should be emphasized that nurses as individuals are holders of personal prejudices, beliefs, and values, which influence attitudes and behaviors towards the family in the performance of their professional activities²², and may imply the insertion of this social group in the care process. However, nurses should welcome the family members at the time of access to the hospitalization unit for

the construction of bonds, free of any pre-judgments so the family can identify the safe harbor they need in the professionals. In this perspective, the family becomes a nursing client and, on its own, suggests an interactive process in which closeness and attachment give body and structure to care and where bridges are created to sustain and enable new interactions. In this context, communication promotes capacity for expression that, in addition to breaking the loneliness, represents a connection with others and satisfaction of the intellectual, affective, moral and social needs, constituting an essential component of the life of each one and in particular of the whole system family²³. Therefore, it is imperative that the nurse has an attitude of cooperation with the family, based on their autonomy and ability to understand and assimilate the knowledge transmitted by the nurse.

To consider the family as a burden is to place this group out of reach of the nurses' actions and to consider it as a stressful factor, besides representing an impediment to nursing care. Old practices of care are exemplified in the attitudes of nurses who recognize families as burdens, such as not having time to care for this group. They are attitudes that disregard the different dimensions that the family has, excluding this group from the care process. Attitudes like this make family members feel uncomfortable, that is, they do not feel cared. Considering the family as a burden can be important evidence that nurses establish priorities in their professional activity and that these may not include family involvement in nursing care⁷. However, it is necessary to consider that adopting the concept that the family is a burden is a barrier to the development of a collaborative relationship between nurses and families and may be related to personal, organizational and environmental barriers.

The family requires assistance from both its own support network and other close people as well as health professionals.²⁴ This is due to the fact that emotional and physical overload is related to constant exposure to the demands of care, beyond the need that the companion has to perform other activities outside the hospital care.²⁵ In the same way, the companion represents support and support during the treatment and recovery of the hospitalized person and their presence implies maintaining affectivity, offering emotional support and the possibility of maintenance of the link with their social network during the period of hospitalization²⁶. They are

perspectives that reaffirm the family as a unit of care. It is up to the nurse to recognize it as such and to understand that effective care is concretized as this understanding permeates the nursing-family relationship.

CONCLUSION

The nurse must hold attitudes that imply in the capacity to admit the partnership with the family, and, often, the nonobservance of this perspective excludes this family group from the care process, as well as in the partnership between professional and family.

Regarding the dimension Family: dialogue partner and coping resource, nurses considered important that family members should be invited to participate actively in nursing care to the patient; that in the first contact with the family members the nurses invited the family to participate in the discussions about the patient care process and always sought to know who the members of the patient's family were. Therefore, in this dimension, nurses recognize as important the shared care, dialogue and negotiation that implies the ability to discuss with the family members about the process of care, talking and talking about the patient's condition. These attitudes are characteristics that determine care based on horizontal and complementary relationships marked by openness to new and diverse opinions, as well as to the reception of them, and involve the capacity to value family experiences, flexibility, tolerance and reflective thinking.

The study nurses recognize the importance of dialogue and the ability to guide family members about the care process and to talk about the patient's condition. The way nurses involve the family in care has received special emphasis in this study. The partnership between the team and the family portrays the appreciation of the quality of care, a key feature of humanized care. In contrast, nurses disagreed with how important it was to invite family members to give their opinion on care planning. This attitude may reveal a relationship of power, of valorization of the illness and of the instrumental technique, and reveal indifference in the care relationships in which nursing focuses on the disease, not the individual and his family.

Regarding the Family dimension: nursing care resource, the nurses' attitudes to accept that it is important to know who the family members of the patient were; they agreed that a good relationship with family members gave them satisfaction at work; that the presence of family members was important to nurses and they reveal attitudes to observe

the family as a care partner, placing it at the center of attention and focusing on it as an essential element of their actions.

In the attitudes that delimit the dimension Family: burden, the nurses disagreed that the presence of family members makes their work difficult and they did not have time to take care of the families. The study nurses did not consider the family as a burden because they put this group into their actions and did not consider it as a stressing factor in nursing care relationships.

It is considered that the information obtained by this study can help the nurse to identify the attitudes that contribute and/or imply for the valorization of the families in the nursing care practices of the Intensive Care Unit.

REFERENCES

1. Silva FDS, Chernicharo IM, Silva RC, Ferreira MA. Discursos de enfermeiros sobre humanização na unidade de terapia intensiva. Esc. Anna Nery R Enferm. BRA [Internet]. 2012 [cited 2016 Oct 2];16(4):719-27. Available from: <http://www.scielo.br/pdf/ean/v16n4/v16n4a24.pdf>.
2. Saiote E, Mendes F. A partilha de informação com familiares em unidade de tratamento intensivo: importância atribuída por enfermeiros. Cogitare Enferm [Internet]. 2011 [cited 2017 Feb 2];16(2):219-25. Available from: <http://www.scielo.br/pdf/ean/v16n2/v16n2a24.pdf>.
3. Predebon GR, Beuter M, Flores RG, Girardonperlini NMO, Brondani CM, Santos NO. A visita de familiares em unidades intensivas na ótica da equipe de enfermagem. Cienc Cuid Saude [Internet]. 2011 Jan/Mar [cited 2017 Mar 12];10(4):705-12. Available from: <http://periodicos.uem.br/ojs/index.php/CienCuidSaude/article/view/23360/12457>.
4. Wrigth L, Leahey M. Enfermeiras e Famílias: Um guia para a avaliação e intervenção na família. 4th ed. São Paulo. Roca; 2011.
5. Pinto JP, Ribeiro CA, Pentegill MM, Baleiro MMFG. Cuidado centrado na família e sua aplicação na enfermagem pediátrica. Rev bras Enferm [Internet]. 2010 [cited 2017 Jan 10];63(1):132-5. Available from: <http://www.reben.abennacional.org.br/detalhes/3802/>.
6. Johnson B, Abraham M, Conway J, Simmons L, Edgman-Levitan S, Sodomka A. Institute for family-centered care. Partnering

Chaves RGR, Sousa FGM de, Silva ACO et al.

Importance of the family in the care process...

with patients and families to design a patient- and family-centered health care system. Bethesda MD: 2008.

7. Ângelo M, Cruz AC, Mekitarian FFP, Dos Santos CCDS, Martinho MJCM, Martins MMFPS. Atitudes de enfermeiros em face da importância das famílias nos cuidados de enfermagem em pediatria. Rev Esc Enferm USP [Internet]. 2014 [cited 2017 Mar 15]; 48 (Esp):75-81. Available from: http://www.scielo.br/pdf/reeusp/v45n1/en_02.pdf75-81

8. Gottlieb L. O cuidar em Enfermagem baseado nas forças: saúde e cura para a pessoa e família. Portugal: Lusodidacta, 2016

9. Sousa FGM, Erdmann AL. Qualificando a atenção à criança na Atenção Primária de Saúde. Rev bras Enferm [Internet]. 2012 [cited 2017 Jan 1]; 65(5):795-802. Available from: <http://www.reben.abennacional.org.br/detalhes/3802/>.

10. Siegel DJ. The mindful therapist: a clinician's guide to mindfulness and neural integration. New York, W.W. Norton, 2010.

11. Erdmann AL, Sousa FGM. Cuidando da criança na Atenção Básica de Saúde: atitudes dos profissionais e saúde. Rev Mundo da Saúde [Internet]. 2009 [cited 2017 Apr 2]; 33 (2):150-60. Available from: <http://www.scielo.br/pdf/ean/v33n2/v33n2a24.pdf>

12. Bailey J, Sabbagh, M, Loiselle CG, Johanne Boileau J, McVey L. Supporting families in the ICU: a descriptive correlational study of informational support, anxiety and satisfaction with care. Intensive and critical care nursing. [Internet]. 2010 [cited 2017 Apr 4]; 26(2):114-22. Available from: <http://www.scielo.br/pdf/ean/v26n2/v26n2a22.pdf>.

13. Meriläinen M, Kyngäs H, Ala-kokko A T. Patients' interactions in the intensive care unit and their memories of intensive care: a mixed method study. Intensive and critical care nursing [Internet]. 2013 [cited 2017 Apr 4]; 29(2):78-87. Available from: <http://www.scielo.br/pdf/ean/v29n2/v29n2a26.pdf>.

14. Ferreira M, Dias M. Ética e profissão: relacionamento interpessoal em enfermagem. Loures: Lusociencia; 2009.

15. Mendes A. A informação à família na Unidade de Cuidados Intensivos: desalojar o desassossego que vive em si. Loures: Lusodidacta; 2015.

16. Blanchard B, Alavi C. Asymmetry in the intensive care unit: redressing imbalance and

meeting the needs of Family. Nursing in critical care. [Internet]. 2008 [cited 2017 Mar 3]; 53(4):480-87. Available from: <http://www.scielo.br/pdf/ean/v53n4/v53n4a22.pdf>.

17. Ergstrom B, Uusitalo A, Engstrom A. Relatives' involvement in nursing care: a qualitative study describing critical care nurses' experiences. Intensive and critical care nursing. [Internet]. 2011 [cited 2017 Jan 10]; 27(3):1-9. Available from: <http://www.scielo.br/pdf/ean/v27n1/v27n1a26.pdf>.

18. Sampaio PSS, Ângelo M. Cuidado da família em pediatria: vivência de enfermeiros em um hospital universitário. Rev. Soc. Bras. Enferm. Ped [Internet]. 2015 [cited 2017 Apr 20]; 15(2):85-92. Available from: <http://www.scielo.br/pdf/tce/v15n2/15>.

19. Baggio MA, Erdmann AL, Dal Sasso GTM. Cuidado humano e tecnologia na enfermagem contemporânea e complexa. Texto contexto - enferm [Internet]. 2010 Oct/Dec [cited 2017 Apr 15]; 19(2):378-85. Available from: <http://www.scielo.br/pdf/tce/v20n4/15>.

20. Pimenta EAG, Collet N. Dimensão cuidadora da enfermagem e da família na assistência à criança hospitalizada: concepções da enfermagem. Rev Esc Enferm USP [Internet]. 2009 [cited 2017 Apr 15]; 43(3):622-9. Available from: http://www.scielo.br/pdf/reeusp/v45n1/en_02.pdf.

21. Araújo I. Cuidar da família com um idoso dependente: formação em enfermagem. Porto: Universidade do Porto, Instituto de Ciências Biomédicas Abel Salazar. 2010. [cited 18 Mar 2017]. Available from: http://repositorio-aberto.up.pt/bitstream/10216/45001/2/Doutl_sabel.pdf.

22. Rodrigues LMO. A Família Parceira no Cuidar: intervenção do enfermeiro. Coimbra. Escola Superior de Enfermagem de Coimbra. 2013. [cited 14 Apr 2017]. Available from: <http://repositorio-aberto.up.pt/bitstream/111516/45001/2/Doutrodrigues.pdf>.

23. Dias MO. Um olhar sobre a família na perspectiva sistêmica: O processo de comunicação no sistema familiar. Rev. Gestão e Desenvolvimento. [Internet]. 2011 [cited 2017 Jan 1]; 15(2):110-8. Available from: <http://www.scielo.br/pdf/ean/v15n2/v15n2a08.pdf>.

24. Beuter M, Brondani CM, Szarek C, Cordeiro FR, Roso CC. Sentimentos dos familiares acompanhantes. Esc Anna Nery R Enferm [Internet]. 2012 [cited 2017 Mar

Chaves RGR, Sousa FGM de, Silva ACO et al.

Importance of the family in the care process...

3];16(1):134-40. Available from:
<http://www.scielo.br/pdf/ean/v16n1/v16n1a24.pdf>.

25. Santos QN. Estratégia de enfrentamento (coping) da família ante um membro familiar hospitalizado: uma revisão de literatura brasileira. Mudanças - Psicologia da Saúde. [Internet]. 2013 [cited 2017 Feb 2];21(2):40-7. Available from:
<http://www.scielo.br/pdf/ean/v21n2/v21n2a24.pdf>.

26. Sanches C D, Santos T C S, Carvalho CMF, Sá ACM, Paixão GPN. Relacionamento enfermeiro, paciente e família: fatores comportamentais associados à qualidade da assistência. RevEnferm UFSM [Internet]. 2013 [cited 2017 Jan 1];14(2):73-7. Available from:
<http://www.scielo.br/pdf/ean/v14n2/v14n2a24.pdf>.

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